Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living &
Department for Behavioral Health, Developmental and Intellectual Disabilities

Participant Directed Services (PDS)
Eligible Employee Form

Participant Name: _____ Participant MAID: _____

PDS Employee Name: _____ Employee SSN: _____

Employee Address: _____

Employee Telephone: _____ PDS Employee Date of Birth: _____

CM Name: _____

_____Copy of the Signed PDS Member Contract (please attach)

MAP 532 (if applicable) Date Approved: _____
If transporting a participant only:
Valid Driver's License (Renew upon expiration) Date Completed: _____
Liability Insurance (Renew upon expiration) Date Completed: _____

Background check **(Must be completed prior to employment)**
AOC check Date Completed: _____
Nurse Aide Abuse Registry Check Date Completed: _____
Drug Screening Date Completed: _____

(Must be completed within thirty (30) days after employment)
Central Registry check Date Completed: _____
TB Screening (Renew upon expiration) Date Completed: _____

Training Requirements **(Must be completed within six (6) months after employment for new hires; existing employees transitioning with participants must complete within one (1) year)**

First Aid and CPR (Renew upon expiration) Date Completed: _____
Kentucky College of Direct Supports Date Completed: _____
- Maltreatment of vulnerable adults & children Date Completed: _____
- Individual Rights and Choices Date Completed: _____
- Safety at home and in the Community Date Completed: _____
- Supporting Healthy Lives Date Completed: _____
- Person centered planning Date Completed: _____

Other _____ (if applicable) Date Completed: _____

By providing this document to the designated Financial Management Agency, I have reviewed and determined the PDS employee has met and completed the requirements as stated in KAR 12:010 and 12:020.

_____ _____
Case Manager Signature **Date**